SD/MC Billing FAQ

Medi-Medi Certification Q and A
(Clarification of DMH Information Notice 11-04)

SUMMARY

Federal and state law require the Medicaid (Medi-Cal) program to be the payer of last resort. Therefore, providers are required to bill payers, such as Medicare, for services provided to dual eligible beneficiaries prior to billing Medi-Cal. However, for Medi-Cal Specialty Mental Health Services, a primary issue is that most of the services are authorized by the Rehabilitation Option, which provides significant staffing and service flexibility to assure beneficiary access to appropriate community based services that may be provided in community based settings by multi-disciplinary teams. Medicare will not reimburse Specialty Mental Health Services whenever one or more of the following three conditions exist:

- The service is not covered as a Medicare benefit.
- The provider does not meet Medicare provider qualifications.
- The location where the service is provided will render the service ineligible for Medicare reimbursement.

DMH Information Notices 09-09, 10-11, 10-23, and 11-04 describe the services, provider types, and service locations for which neither Medicare certification of the provider (county MHP or subcontractor) nor prior billing of the claim to Medicare are necessary. The current list of related Medi-Medi edits is described at the following link: SD/MC II Dual Coverage Billing Edits

The Medicare certification procedures (as established in DMH Information Notice 11-04) are required to be followed only where the service, provider type and place of service (or setting) all meet the requirements for Medicare reimbursement. In those situations, unless the certification procedures have been followed, the claim cannot be paid by the Short-Doyle Medi-Cal Phase II (SD2) system.

Thus, in order for county MHPs to be paid for the services which do qualify for Medicare, the county MHPs and all of their subcontractors must apply for Medicare certification if they have not already done so. DMH will file the result of this Medicare certification request and add it to the DMH Provider file used to adjudicate those SD2 claims for which Medicare reimbursement is or could be eligible (that is, those claims where the service, provider type, and service location are all Medicare eligible).

Those providers that apply and meet Medicare's provider qualifications will become Medicare providers. Such providers must then bill Medicare before billing Medi-Cal for Medicare eligible covered services provided to dual eligibles.

Those providers that apply but do not meet Medicare's provider qualifications will not become Medicare providers. For such providers, proper documentation that demonstrates that the provider applied, but did not qualify to be a Medicare provider, will allow adjudication of their claims without a service-specific Medicare denial or rejection for services provided to dual eligibles.

QUESTIONS AND ANSWERS

Q1: Can the State allow an administrative waiver of the state 6 month and 97 day late claims procedures for Medi-Medi claims to account for the delays in processing which will be associated with implementation of these new Medicare certification requirements by the MHPs and their subcontractors?

> A1: The State does not have the authority to waive Title 9 timeliness regulations. However, the MHP may use Good Cause Delay Reason Code (DRC) '3' for claims delayed due to Medicare / Medi-Cal billing implementation as described in DMH Information Notices 09-09, 10-11, 10-23, and 11-04. DRC 3 will allow counties to submit claims for dual eligible clients that are older than six months from the month of service but less than one year from the month of service. DRC 3 may be used for original or replacement Medi-Medi claims delayed due to implementation of new State edits for Medi-Medi billing. Medi-Medi replacement claims submitted due to the new edits will be exempt from the 97 day replacement rule.

Q2: Can the State temporarily suspend the Medi-Medi edits for Medication Support and Mental Health Services delivered by licensed MSWs [*DMH interprets this to mean Licensed Clinical Social Workers (LCSWs)*] and Psychologists to allow for Medi-Cal adjudication during the MHP Medicare certification application phase? Once completed and approved by Palmetto the MHP will submit the claims for Medicare reimbursement and the Medicare payment will be adjusted for during CPE interim payment reconciliation and cost settlement process. Since Medicare payments are relatively small the adjustments to these two service modes will be minimal and appropriately addressed during settlement consistent with federal CPE interim reimbursement and settlement requirements.

> A2: As explained in the Summary (at page 1), federal and state law require the Medicaid/Medi-Cal program to be the payer of last resort, meaning all other available third-party payers (including Medicare) must be exhausted before Medi-Cal can pay for the care of an eligible individual. [See title 42, Code of Federal Regulations, sections 433.135, 433.139 and 433.154 which refer to third-party liability under federal law and title 22, California Code of Regulations, sections 50761 and 50778 which refer to third-party liability under state law.] However, the state is willing to discuss with CMS the concerns raised regarding Palmetto and the amount of time required before an applicant receives a certification denial letter in an effort to determine whether CMS would approve a modified claim processing procedure as described above. Please note that such a procedure cannot be implemented until the State receives approval from CMS.

Q3: What are the programs that bill Medi-Cal but do not provide services to Medicare or Medi-Medi beneficiaries? Based on what is written in DMH Information Notice 11-04, is it correct that these related providers do not need to be certified?

> A3: Please refer to the Summary (at page 1) for a response to this question.

Q4: How is an organization defined?

> A4: The term “organization” is not specifically referred to in DMH Information Notice 11-04. The appropriate terms, as defined by Medicare, for purposes of Medicare certification are “provider,” “group provider,” and “rendering provider.”

Q5: What is a “Provider Type that is subject to Medicare certification”?

> A5: Provider Types that are subject to Medicare certification can be found on the Medicare website at the following link. http://www.cms.hhs.gov/Manuals/IOM/list.asp